THE PETER ROONEY FOUNDATION

FISCAL YEAR JANUARY 1 – DECEMBER 31

LAST CONSIDERATION FOR APPLICATION IS NOVEMBER 1ST OF EACH YEAR

AUTHORIZATION: Physicians signature is required on ALL requests for financial assistance.

CONFIDENTIALITY: Insofar as is possible, the record keeping systems shall be maintained to keep the names of clients confidential.

DISCRETION OF THE PETER ROONEY BOARD MEMBERS: The Board Members are granted discretion in meeting requests for assistance.

FINANCIAL ASSISTANCE LIMITATION: There is no exclusion provided documentation substantiates a relationship to a medical situation. ALL REQUESTS FOR FINANCIAL ASSISTANCE ARE DEPENDENT ON AVAILABILITY OF FUNDS.

APPLICATION FOR ASSISTANCE: Requests should be made to THE PETER ROONEY FOUNDATION prior to or at the time of need for the service. Retroactive expenses incurred before the application for assistance can only be considered during the current fiscal year and upon the receipt of appropriate receipts.

THE PETER ROONEY FOUNDATION

CLIENT SERVICE POLICY

THE PETER ROONEY FOUNDATION provides a family with financial assistance and/or reimbursement for medical expenses and expenses related to medical treatment, including travel, lodging, meals, sibling childcare and other related expenses

Please return the attached completed data form to **The Peter Rooney Foundation, P.O. Box 2179, Wrangell, Alaska 99929.** Your application for assistance will be reviewed by board members of **PETER ROONEY FOUNDATION. (Last application consideration date is November 1st of each year).**

Please be sure your name, address and contact phone number are indicated on the application and the type of assistance requested. Your physician's signature must appear in Part III of the application.

Please attach copies of bills and/or receipts for which you are seeking reimbursement and/or payment. You may also send a letter of explanation of your circumstances if you wish.

THE PETER ROONEY FOUNDATION
PO BOX 2179
WRANGELL, AK 99929
(907) 874-2061
http://www.peterrooneyfoundation.com/

TO WHOM IT MAY CONCERN:

Enclosed please find a packet from **THE PETER ROONEY FOUNDATION. THE PETER ROONEY FOUNDATION** was created to assist families with children between birth and 18 years of age who are dealing with life threatening illnesses and who may be in need of assistance.

The Foundation allows families to apply for funds to cover anything that is related to their child's illness. All requests for financial assistance are depended on availability of funds. The families are eligible to apply one time per year.

This letter serves as your authorization to make copies of the required application as needed. Once the application is completed and the required documentation is included, please send the application to **THE PETER ROONEY FOUNDATION, P.O. BOX 2179, WRANGELL, AK 99929.** Distributions are made quarterly during the fiscal year, which is January 1 to December 31. Should you have questions, please call Sharry Rooney at (907) 874-2061.

Sincerely,

Board Member

Enclosures

THE PETER ROONEY FOUNDATION
PO BOX 2179
WRANGELL, AK 99929
(907) 874-2061

PART I
Patient Information (to be filled out by parent/guardian)

Name of Patient _____ Date of Birth _____

Address (City, State, Zip) _____ Telephone No. & Area Code _____

Social Security Number (Child) _____ Birthplace _____ Total Years Alaska Resident _____

Diagnosis _____

Primary Physician's Name _____ Telephone No. & Area Code _____

Primary Physician's Address _____ City _____ State _____ Zip _____

Name of Mother and/or Guardian _____ Name of Father and/or Guardian _____

Address _____ City _____ State _____ Zip _____ No. of Years in Alaska _____

Part II (To be filled out by parent/guardian)

A. Family Financial Information (Please attach copy of last tax return filed)

1. Monthly Gross Income (all sources, including public assistance, Federal of State Benefits) $_____

2. Insurance Information (please circle all that apply and fill in identifying information)

TYPE	CARRIER	GROUP #	ID#
Medicaid			
Private Medical Insurance			
Other Insurance			

B. Assistance Requested

1. Funding is requested for the following:_____
_____
_____
_____

Part III (To be filled out by the physician)

A. 1. Diagnosis_____

2. Date of Diagnosis_____

3. Name of Facility_____

4. Prognosis_____

_____

Part III (To be filled out by the physician con't.)

B. 1. Certification of Physician:

This patient has a confirmed diagnosis of_____

_____

_____

_____ _____

Primary Physician's Signature Telephone No. & Area Code

_____

Primary Physician's Name (Please Print)

*Please attach letter from the physician confirm the details shown above.

Part IV

A. Support Network (To be filled out by Physician and/or hospital social worker)

SOCIAL SERVICE AGENCIES	CONTACT NAME	TELEPHONE NO.
_____	_____	_____
_____	_____	_____
_____	_____	_____
HOSPITAL/MEDICAL CENTER	CONTACT NAME	TELEPHONE NO.
_____	_____	_____
_____	_____	_____
_____	_____	_____

ELIGIBILITY (To be completed by the primary physician and/or hospital worker)

I hereby certify that this patient is eligible for the assistance requested under the terms of the Service Policy of the PETER ROONEY FOUNDATION.

_____ _____

Date Primary Physician and/or Hospital Social Worker

PLEASE NOTE: PROOF OF FINANCIAL NEED AND COPIES OF BILLS, AIRLINE TICKETS, ETC., MUST BE RECEIVED ALONG WITH APPLICATION BEFORE REIMBURSEMENT CAN BE MADE.

APPROVED: _____

DATE: _____

THE PETER ROONEY FOUNDATION

CHECKLIST

1. Patient information (to be filled out by parent/guardian) _____
2. Parent's and/or guardian information_____
3. Family financial information_____
4. Proof of financial need through legal documents (example: last individual tax return information or other source)_____
5. If your insurance is not covering needs due to the medical situation you are facing, you may attach a letter of explanation (example: does not cover travel for both parents, medicine, medical supplies, etc.,) _____
6. Assistance request (funding is requested for the following) _____
7. Section to be filled out by physician_____
8. Signature of the physician_____
9. Support Network (to be filled out by physician and/or hospital social worker_____
10. Attached copies of bill and/or receipts for which you are seeking reimbursement and/or payment_____
11. Letter of explanation (optional)_____

The application must be complete and all above information provided for the application to be considered.